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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Mr. Chairman and Members of the Committee.

It is a pleasure to appear before you today to discuss long-term care insurance, and particularly the Partnership program. We are pleased that you are holding this hearing to focus on this issue, which is so important to all Americans, especially to us aging baby boomers. We may not be ready to admit it, but in increasing numbers we will require long-term care.

People want to stay in their own homes as long as possible. Giving people more choice and more control over the long-term care services they receive leads to higher quality care and greater satisfaction. The Medicaid program is currently the largest public payer of long-term care services. Data from the U.S. Census Bureau and CMS makes it abundantly clear that Medicaid – the "last house on the block" for financing long-term care-- is not going to be able to rise to the demographic challenge. Nor is it fair to expect it to. Furthermore, the basic structure of Medicaid, which dictates who receives services and how they receive them, is unlikely to work for the baby boomers, who are used to controlling their own destinies to the greatest extent possible.

With long-term care insurance, people can choose to stay in their own home or to go into a nursing home or another care setting, depending on their needs and condition. They are not restricted by the limitations of what public money will cover. As it becomes increasingly difficult to sustain public financing of long-term care, private pre-funding becomes more important. Long-term care insurance is critical to allow people to pre-fund their long-term care needs. The Administration supports measures to encourage people who can afford it to pre-fund their own long-term care by purchasing long-term care insurance. Encouraging baby boomers to pre-fund their own long-term care needs will reduce the financial burden on their children's generation and target Medicaid dollars to those who need them the most. The Administration continues to support passage of legislation providing an above the line tax deduction. This kind of deduction would be available to all taxpayers whether or not they have medical expenses above 7.5% of their adjusted gross income. The legislation that this committee is discussing today is an important step in encouraging people to take responsibility to protect their own independence with long-term care insurance.

The Partnership legislation would give states more flexibility under Medicaid to encourage the purchase of long-term care insurance. It would permit them to exclude from the estate recovery process the amount paid by qualifying long-term care insurance. The Omnibus Reconciliation Act of 1993 allowed programs that had already been approved by the Health Care Financing Administration to operate as approved, but prevented the expansion of Partnership programs by instituting a set of new requirements that states had to observe in order to offer a Partnership program. The requirements are

contained in the estate recovery sections of Medicaid law (Section 1917 (b)). Several states attempted Partnership programs under the requirements and found them unworkable for the state and for consumers.

The Partnership legislation you are considering would reverse these provisions. This change is needed. It is good for states, who tell us that long-term care is the most expensive part of their Medicaid budgets. It is good for consumers who value choices and maintaining their independence. And, ultimately, it is good policy for our country.

The Need for Long-Term Care

The Congressional Budget Office estimates that spending on long-term care for the elderly in 2004 will total about $135 billion. While families and other informal caregivers provide the bulk of unpaid services, Medicaid is responsible for the largest share of the cost of paid services. Medicaid currently pays for approximately 35 percent of formal long-term care services with self-pay payments representing 33 percent and Medicare representing 25 percent. Private insurance and Other Sources together make up only 7 percent. In 2002, Medicaid accounted for more than 20 percent of total state spending. Furthermore, state Medicaid budgets continue to grow at a faster pace than other types of state spending.

The U.S. Census Bureau estimates that the number of elderly people in the United States will double between 2000 and 2030. By 2050, 21.5 percent of the population will be

over 65. My office estimates that total spending for long-term care for the elderly will increase from $102 billion in 2000 to $260 billion by 2025. Medicaid's share of long-term care costs in 2025 is projected to be roughly $83 billion. There is little question that the increase in demand for publicly supported long-term care far exceeds our current financing system's capacity.

THE PARTNERSHIPS PROGRAM WORKS

Four states are now operating successful Partnerships programs—California, New York, Indiana, and Connecticut. They are able to do so because their programs were in place prior to the enactment of OBRA '93, which stopped the growth of this popular program. (One additional state, Iowa, was approved by HCFA to operate a program, but unable to get the a successful program up and running.)

We have learned a great deal from these states' experiences. They demonstrate that states can engage consumers in planning ahead for their potential long-term care needs, and that private and public resources can be combined in a way that benefits consumers, states and the federal government.

REASONS FOR ACTION

Why is it critical that we make this option available again? First, the Partnership expands the market for long-term care insurance to those who otherwise might not be able to participate by offering products that provide coverage for as little as one year, then allow the purchaser to retain some assets and go onto Medicaid. In general, private long-term care insurers rarely offer one-year products because consumers don't want a product that covers only a portion of the anticipated risk. With Medicaid as a backup to private insurance, these shorter-duration, comprehensive policies become a viable alternative. Premiums for private long-term care insurance have been rising due to falling lapse rates and other factors. This trend threatens to make private insurance affordable only to those with significant income or assets. The population able to afford the higher premiums is less likely to require Medicaid and is of less concern for public policy. Partnership policies expand the market to those with less income and assets by offering a shorter term, comprehensive policy that is backed by Medicaid. Such a policy is not available without the Partnership. The Medicaid back-up makes the purchase of such a policy affordable because of its short duration and desirable because of Medicaid's coverage beyond insurance. The availability of Partnership products makes participation in an insurance pool possible for a broader population, especially those likely to eventually need Medicaid.

My office was able to obtain insurance industry data that allowed comparison of long-term care insurance sales in states with Partnership to those without. The data suggest that sales of long-term care insurance in states with Partnership programs were increasing faster than those without Partnership programs.

Second, the Partnership provides an alternative to transfer of assets. Consumers have an increasing number of ways to avoid "spending down" to Medicaid eligibility. We all know that this type of "estate planning" is big business. The Department is currently assessing the impact of products being marketed as "Medicaid Friendly Annuities." The Connecticut Partnership surveyed its participants and found that roughly one-third of respondents said they would have transferred their assets to become Medicaid eligible if they had not purchased a Partnership policy. Partnership insurance policies represent a real alternative to "gaming" Medicaid eligibility.

Finally, but most importantly, the Partnership program offers a way for consumers to finance their own care and to control how and where they obtain the long-term care services they may need. It empowers them to purchase long-term care insurance, which gives them cash with which to buy long-term care services. With this money they can continue to stay at home for as long as possible, if that is their choice.

PARTNERSHIP COST ESTIMATES

The Partnership was designed as a budget neutral program. The participating states hoped that they could offset state losses associated with the limited Medicaid eligibility asset disregard by having fewer people need long-term care under Medicaid. Cost

estimates conducted by the researchers at the University of Maryland[1] confirmed the program design and showed budget neutral or small savings for the program. Recently, the CMS Office of The Actuary also estimated that the Partnership would have a budget neutral impact on Medicaid.

The average age of Partnership policy purchasers, at the time they buy the policy, is roughly 60. Most of these buyers will not be using long-term care services for at least twenty years. After that they must first exhaust their insurance benefits, then spend down any assets in excess of their Partnership protected assets, and finally, qualify for Medicaid. In the twelve years since the inception of the four state Partnership programs approximately 180,000 policies have been sold, just over 2,000 policyholders have received insurance payments, yet only 86 people have gone on Medicaid.

There have been a number of other estimates of the long-range impact of Partnership on Medicaid including a simulation modeling approach conducted by the University of Wisconsin, and several individual state program estimates based on actual program data. Each of these has found either small savings or budget neutrality.

PARTNERSHIP IN CONTEXT

[1] Cost effectiveness conducted by Mark Meiners at the University of Maryland in 1993 using the using the *Lewin Long-Term Care Simulation Model*

The Partnership alone is not the answer to the Nation's long-term care financing problem, but is an important component of an overall effort to reform how we pay for long-term care. The larger picture of long-term care financing reform includes the following major policy initiatives:

First, consumers remain largely unaware of their risk for needing long-term care and the things they can do to plan ahead. New financing alternatives have little hope of succeeding unless baby boomers become aware of their risk and believe they need to act. The Department is planning to conduct pilot long-term care educational campaigns in four states early in 2005. Our hope is that these campaigns will help make planning for long-term care an integral part of planning for retirement.

Second, the baby boom generation will demand a wide array of options. Attitudes about long-term care are widely divergent. Financing alternatives need to address not only differing attitudes but also the differing financial circumstances. Not everyone will buy long-term care insurance. In addition to supporting the Partnership, the Department is exploring other financing alternatives such as home equity conversion, and long-term care annuities. Home equity conversion provides funds to the homeowner that can be used for any purpose, including long-term care costs. A long-term care annuity combines income support with long-term care insurance coverage into a single product that addresses both needs and avoids the need for consumers to choose the risk against which they want to insure.

Finally, Medicaid's coverage of long-term care is a critical component of our safety net for older persons. It was intended to serve those who could not provide for their own needs. The Department continues to work with states to improve Medicaid's coverage of long-term care services. Though our Real Choice Systems Change grants, Cash and Counseling demonstrations, the New Freedom Initiative and numerous other programs, state Medicaid programs continually improve the delivery of long-term care services.

CONCLUSION

It has been more than a decade since the passage of Omnibus Budget Reconciliation Act of 1993, the law that constrains expansion of the Partnership program. At that time twelve states had passed legislation enabling state Partnership programs, but only five had been approved for operation of a Partnership program without meeting the new requirements specified of OBRA'93. Some of those states attempted Partnership programs under the requirements set in OBRA and failed while others saw that the requirements in OBRA made it impossible and simply stopped all program activity. No new programs have emerged to challenge the conventional financing route of private pay until impoverishment and then Medicaid.

Currently several states are seeking authority to change Medicaid eligibility policy to increase look-back periods, reduce spousal allowances, expand their definitions of estate, and increase estate recovery activities. These efforts have only limited potential to

contribute to long-term care financing. States cannot hope to finance the long-term care needs of the baby boomers through closing "loopholes" in Medicaid eligibility.

Mr. Chairman, incremental reform is not easy. The Partnership initiative is important because it provides a practical approach to financing long-term care. It is not the only answer or the only approach. It is one part of our strategy to address the demographic challenge we face.

I applaud the Committee's efforts to highlight this issue and your efforts, Mr. Chairman, to pass legislation so that states can get moving. We must continue to develop new ideas for financing long-term care to enable our senior citizens to have more choice in how they obtain supportive services and to enhance the quality of their lives.

I am happy to answer questions.